# Welcome To Our Office

Please Print

Date _____ /_____ /_____ First Visit (Y/N) _____

Patient's Name _____ Age_____ Marital Status (M/S)_____
Last First Middle Initial

If Married, Name of Spouse _____ If Child, Parent's Name _____

Title: Mr. Mrs. Miss Ms. Other_____ Your Sex (M/F) _____

Address _____ City_____ State____ Zip Code_____

Phone (_____)_____ Social Security # _____-____-_____ Date 0f Birth_____

Place of Employment/School_____Cell Phone_____ Business Phone (_____)_____

Occupation_____Email Address: _____ Medicare #_____

Other Group Health Plan and insurance # (if any) _____ Vision Care Plan(if any)_____

Does your work require special vision care? _____ If so, please explain: _____

List ACTIVITIES / HOBBIES you participate in that may require special vision care: _____

How were you referred to our office? _____

Method of Payment: Cash Visa/MasterCard Check

**Medical History**

Medical Doctor_____ Last Visit ____/____/____ Phone (_____) _____

Date of Last Eye Exam: _____

Do you wear glasses? No Yes If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? No Yes If yes, how old is your present pair of lenses? _____

Type of contact lenses: Rigid Soft Extended Wear Other Are they comfortable? Yes No

Are you interested in wearing contact lenses? Yes No

Reason for Today's Visit: _____

Any Special Eye or Vision Problems? _____

Do you have any allergies to medications? No Yes If yes, explain: _____

_____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):

_____

_____

List all major injuries, surgeries and/or hospitalizations you have had: _____

_____

Mark any of the following that you have had: crossed eyes lazy eye drooping eyelid prominent eyelid glaucoma retinal disease cataracts Eye infections Eye injury Other _____

Are you pregnant and/or nursing? No Yes

**Family History**

Please note any family history (parents, grandparents, siblings, children, living or deceased) for the following conditions:

| Disease/Condition | NO | YES | ? | Relationship to You |
|---|---|---|---|---|
| Blindness | | | | |
| Cataract | | | | |
| Crossed Eyes | | | | |
| Glaucoma | | | | |
| Macular Degeneration | | | | |
| Retinal Detachment/Disease | | | | |
| Arthritis | | | | |
| Cancer | | | | |
| Diabetes | | | | |

| | | | | |
|---|---|---|---|---|
| Heart Disease | | | | |
| High Blood Pressure | | | | |
| Kidney Disease | | | | |
| Lupus | | | | |
| Thyroid Disease | | | | |
| Other_____ | | | | |

**INSURANCE SIGNATURE**

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I authorize payment of these benefits directly to **Dr. April Jasper** on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in Item 9 of the HCFA-1500 claim form or electronically submitted claim), my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above. Most medical insurances do not cover refractions which is the testing required to determine your best vision and prescription for glasses. I agree to pay any and all fees not covered by my insurance. I understand that it is my responsibility to verify insurance coverage

Lifetime Patient Signature _____ DATE_____

**Social History** This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

Yes, I would prefer to discuss my Social History information directly with my doctor. (Check box)

Do you drive? No Yes If yes, do you have visual difficulty when driving? No Yes If yes, please describe: _____

Do you use tobacco products? No Yes If yes, type/amount/how long:_____

Do you drink alcohol? No Yes If yes, type/amount/how long:_____

Do you use illegal drugs? No Yes If yes, type/amount/how long:_____

Have you ever been exposed to or infected with: Gonorrhea Hepatitis HIV Syphilis

**Review of Systems** Do you currently, or have you ever had any problems in the following areas (circle correct response):

**Constitutional**

| | | | |
|---|---|---|---|
| Fever, Weight Loss/Gain | N | Y | ? |
| **Integumentary** (skin) | N | Y | ? |
| **Neurological** | | | |
| Headaches | N | Y | ? |
| Migraines | N | Y | ? |
| Seizures | N | Y | ? |
| **Eyes** | | | |
| Loss of Vision | N | Y | ? |
| Blurred Vision | N | Y | ? |
| Distorted Vision/Halos | N | Y | ? |
| Loss of Side Vision | N | Y | ? |
| Double Vision | N | Y | ? |
| Dryness | N | Y | ? |
| Mucous Discharge | N | Y | ? |
| Redness | N | Y | ? |
| Sandy or Gritty Feeling | N | Y | ? |
| Itching | N | Y | ? |
| Burning | N | Y | ? |
| Foreign Body Sensation | N | Y | ? |
| Excess Tearing/Watering | N | Y | ? |
| Glare/Light Sensitivity | N | Y | ? |
| Eye Pain or Soreness | N | Y | ? |
| Chronic Infection of Eye or Lid | N | Y | ? |
| Sties or Chalazion | N | Y | ? |
| Flashes/Floaters in Vision | N | Y | ? |
| Tired Eyes | N | Y | ? |
| **Endocrine** | | | |
| Thyroid/Other Glands | N | Y | ? |

**Ears, Nose, Mouth, Throat**

| | | | |
|---|---|---|---|
| Allergies/Hay Fever | N | Y | ? |
| Sinus Congestion | N | Y | ? |
| Runny Nose | N | Y | ? |
| Post-Nasal Drip | N | Y | ? |
| Chronic Cough | N | Y | ? |
| Dry Throat/Mouth | N | Y | ? |
| **Respiratory** | | | |
| Asthma | N | Y | ? |
| Chronic Bronchitis | N | Y | ? |
| Emphysema | N | Y | ? |
| **Vascular/Cardiovascular** | | | |
| Diabetes | N | Y | ? |
| Heart Pain | N | Y | ? |
| High Blood Pressure | N | Y | ? |
| Vascular Disease | N | Y | ? |
| **Gastrointestinal** | | | |
| Diarrhea | N | Y | ? |
| Constipation | N | Y | ? |
| **Genitourinary** | | | |
| Genitals/Kidney/Bladder | N | Y | ? |
| **Bones/Joints/Muscles** | | | |
| Rheumatoid Arthritis | N | Y | ? |
| Muscle Pain | N | Y | ? |
| Joint Pain | N | Y | ? |
| **Lymphatic/Hematologic** | | | |
| Anemia | N | Y | ? |
| Bleeding Problems | N | Y | ? |
| **Allergic/Immunologic** | N | Y | ? |
| **Psychiatric** | N | Y | ? |

**If you answered YES to any of the above or have a condition not listed, please explain and list medications:**

_____

_____

Doctor's Signature _____ Date_____

**Receipt of Notice of Privacy Practices - Written Acknowledgment Form**

I, (Patient name)_____, have reviewed/received a copy of Advanced Eyecare Specialists - April Jasper, O.D.'s Notice of Privacy Practices.

Signature of Patient/Guardian _____ Date_____